2015 Form Filing Guidance

Webinar Schedule

- May 29th QHP Plan Certification
- June 5th Rate Filings (9:30-11:30AM)
- June 5th Network Adequacy
- June 12th QDP Plan Certification
- June 19th Binder Submission Issues
- June 26th Binder Submission Issues

Filing Timeline

- All QHP rate, form and binder filings must be submitted no later than June 27, 2014
- All rate and form filings for off-Exchange non-grandfathered individual and small group health benefit plans must be submitted no later than July 15, 2014
- Ideally form filings should be approved prior to submittal of rate filings

Product Discontinuation and Renewal

- Proposed definition of plan changes that constitute a uniform modification of coverage (rather than product discontinuation)
  - Changes made solely pursuant to applicable Federal or Nevada law; or
  - Other changes such that the product meets all of the following criteria:
    - Issued by the same licensed issuer
    - Issued as the same product type (e.g., HMO or PPO)
    - Covers a majority of the same counties in service area
    - Has the same cost sharing structure (except for changes to adjust for cost and utilization of medical care or to maintain the same metal level)
    - Same covered benefits (except where does not change index rate in total by more than 2 percent) (not including changes required by Federal or Nevada law)
- Proposed standardized notices of product discontinuation and renewal to improve consumer education and choices

Nevada Discontinuation Statutes

- A carrier may discontinue a health benefit plan if determined to be obsolete and is being replaced with comparable coverage
  - 60 day notice required to the DOI, then
  - 180 day notice required to each policyholder
- A carrier may discontinue a health benefit plan if the Commissioner finds it to be in the best interests of policyholders
  - Noncompliant plans may be discontinued with a 90 day notice to policyholders

Product Filings

- All risk pool products may be submitted within a single forms filing
- All forms for all risk pool plans must be submitted each year
- A product will consist of various plans
- Plans within a product may vary by cost sharing structure
- Benefit variability within a product will not be allowed

Product Filings

- Redlined versions of all forms for existing plans must be submitted
- Clean copies of the schedule of benefits and evidence of coverage for each approved plan must be submitted for display on the DOI website
- PDF of input and output from stand-alone AV calculator for each plan must be included
- Actuarial certification for unique plan designs must be included

Non-Discrimination

- Pursuant to 45 CFR 156.225, plans must not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs
- In addition to the non-discrimination reviews conducted for 2014 with regards to cost sharing outliers, DOI intends to review plans that are outliers based on an unusually large number of drugs subject to prior authorization and/or step therapy requirements in a particular category and class

Consumer Protections: Non-Discrimination Standards

- The final rule prohibits benefit design discrimination based on:
  - Age
  - Expected length of life
  - Disability
  - Medical dependency
  - Quality of life
  - Other health conditions
- Allows for reasonable medical management techniques

Formulary Modifications

- An individual or small group carrier may not:
  - Remove drugs from an approved formulary unless in response to an action of the US Food and Drug Administration
  - Move drugs between benefit tiers once the formulary has been approved by the Commissioner for a plan year
- The DOI has proposed a regulation to be effective later this year

Single Risk Pool

- Index rate must be established and effective for Nevada by January 1 of each calendar year
- Timing and frequency of rate updates:
  - Individual Market: Only annually
  - Small Group Market: Quarterly (beginning July 1, 2014)
    - Standardized rate effective dates (January 1, April 1, July 1 or October 1)
    - Applicable to new and renewing business
    - June 1,2014 submission deadline for 4th quarter index rate adjustment

Premium Changes

- Pursuant to NRS 687B.420, health carriers must provide at least 60 days notice to the policyholder prior to altering any policy terms, including premium
- The terms of an individual policy can only be altered on the anniversary date
- The terms of a grandfathered small group policy can be altered every six months
- Carriers cannot change the anniversary date of a policy without the written consent of the policyholder

Large Group Product Filings

- Other than state mandates, large group products are not required to provide coverage for EHBs
- If a large group product provides coverage for an EHB, then no annual or lifetime dollar limits are allowed for that benefit
- The DOI will review all large group products assuming Nevada's EHB benchmark plan is applicable
- Benefit variability within a large group product is allowed. The filing must include a demonstration that the highest cost-sharing benefit variation of the product meets minimum value

Off-Exchange Templates

- In order to expedite the review process and ease enforcement of market-wide standards, the following Plan Management Templates are required to be submitted for off-exchange plans in the individual and small group market unless a corresponding binder is submitted:
  - Plans & Benefits Template
  - Network Template
  - Service Area Template
  - Prescription Drug Template

Off-Exchange Templates, cont.

- Templates do not have to be validated and only certain fields are required.
- Make sure macros are enabled.
- Excel versions should be submitted within the Supporting Documentation tab in SERFF.
- Templates can be found here: http://www.serff.com/plan_management_data_templates_2015.htm
- Detailed instructions are here: http://www.serff.com/plan_management_instructions_2015.htm

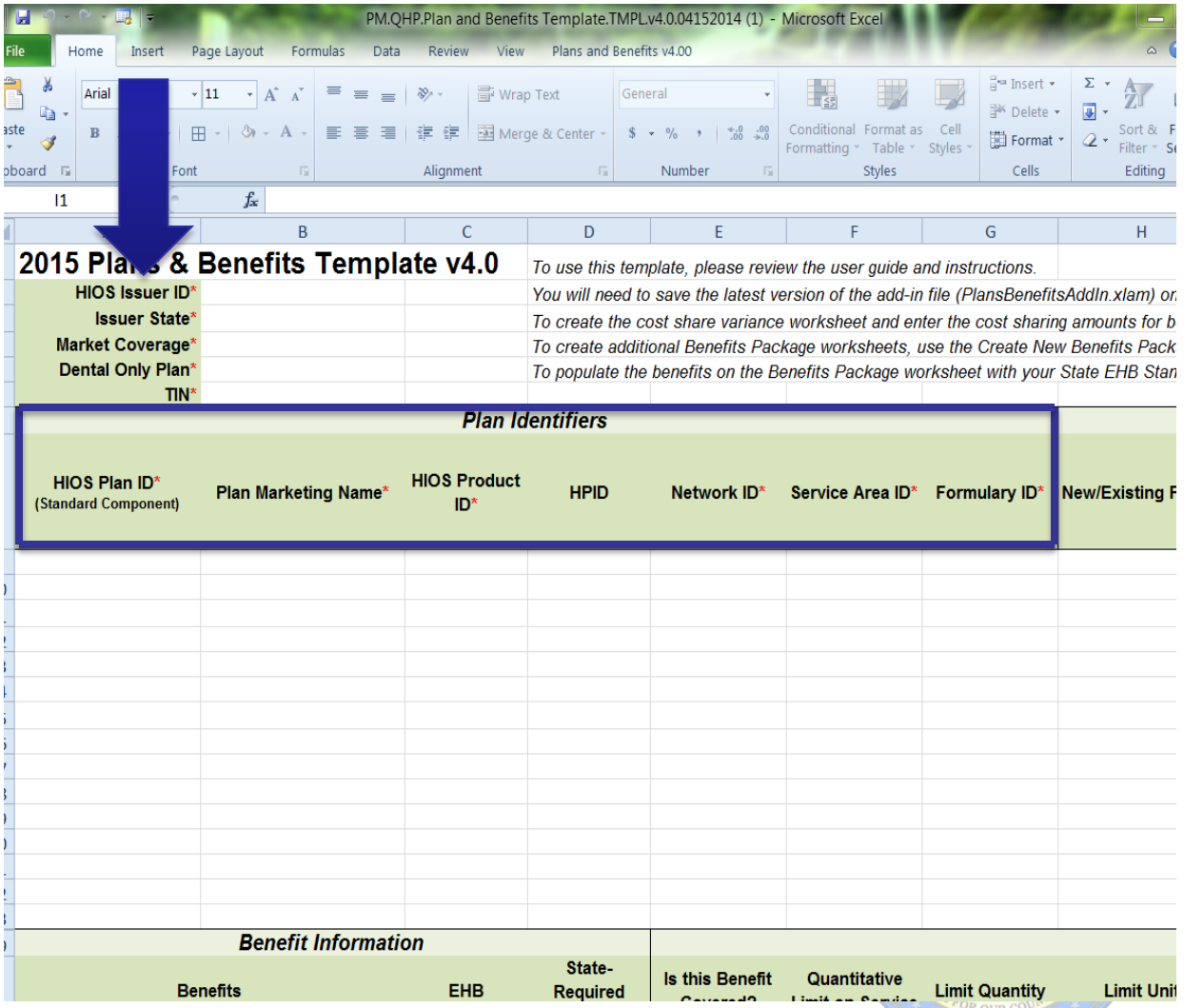
Additional Formulary Requirements

- In addition to the prescription drug template, all filings in the individual & small group market must include with each drug list the following within the Supporting Documentation tab in order to comply with Rx EHBs:
  - Prescription Drug List Output files generated from the CMS Category Class Drug Count Tool
  - Formulary – Inadequate Category/Class Count Supporting Documentation & Justification form

Plans & Benefits Template

Only the General Information and Plan Identifiers sections are required for off-exchange submissions.

- ✓ The Network, Service Area, and Formulary templates should be completed first.

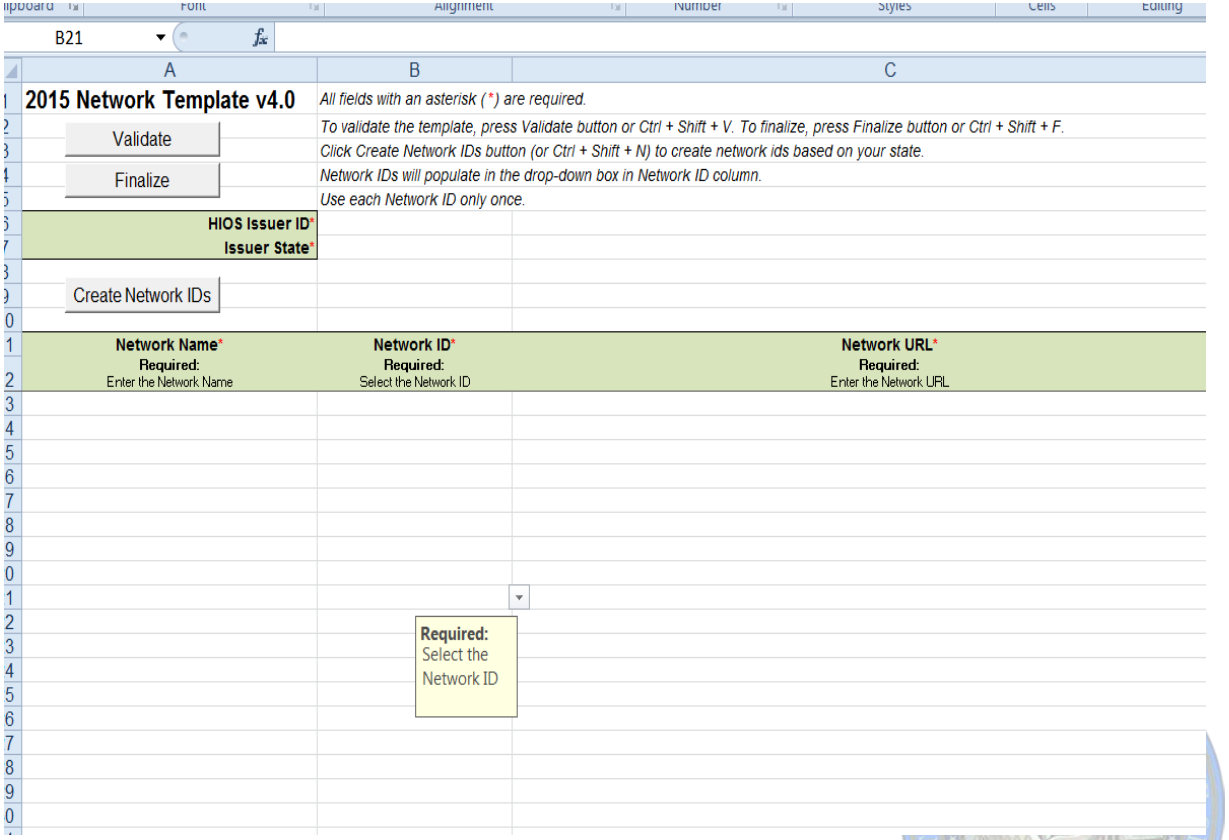


Network Template

All fields are required for off-exchange submissions.

1. Select Issuer State & Enter HIOS ID
2. Push the Create Network IDs button
3. Enter the number of networks you have (creates Network IDs)
4. Complete the Network Name, Network ID, & Network URL for each network

✓ URLs should be a direct link to a list of providers - not a landing page



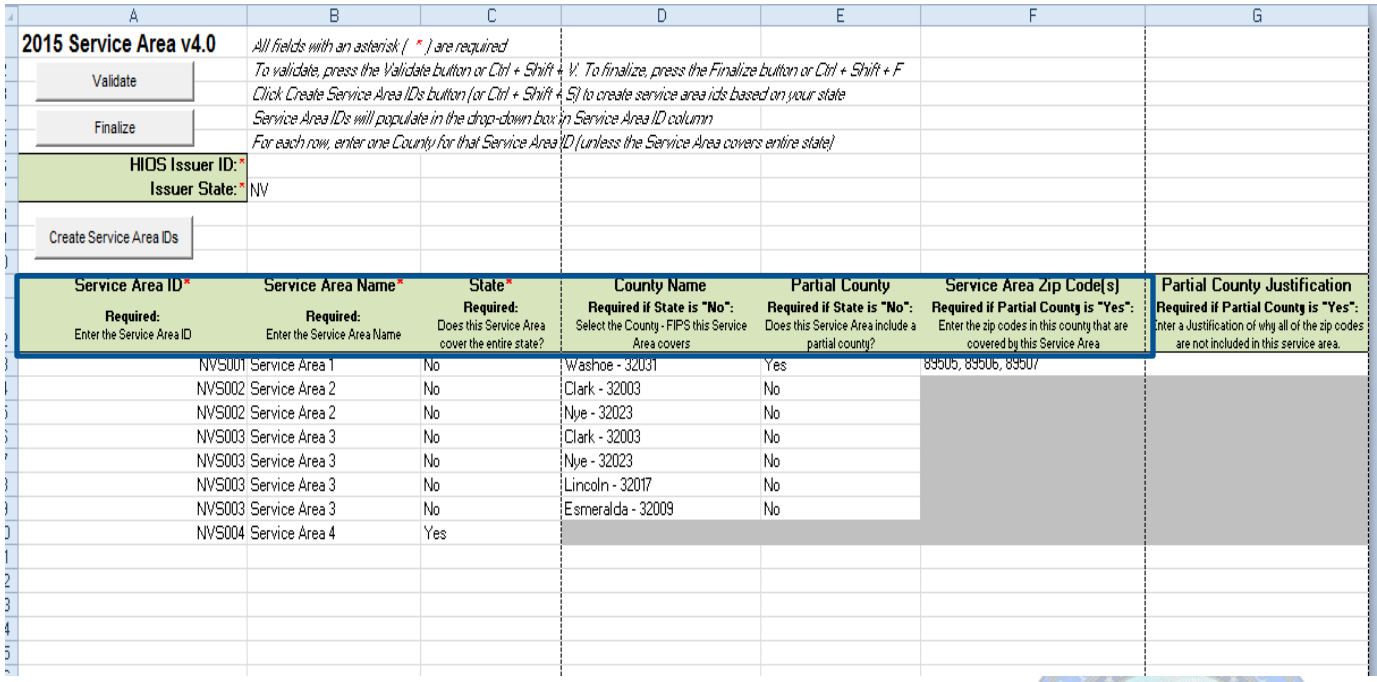
Division of Insurance

Service Area Template

All fields except Partial County Justification are required for off-exchange submissions.

1. Select Issuer State, enter HIOS ID, & create Service Area IDs
2. Proceed to complete fields A-L

- ✓ If a service area includes multiple counties, you must add a new row for each county, using the same service area ID & Service Area Name
- ✓ Service areas are carrier-specific and do not have to correspond to NV's geographic rating areas



2015 Service Area v4.0

*All fields with an asterisk (*) are required*

Validate — *To validate, press the Validate button or Ctrl + Shift + V. To finalize, press the Finalize button or Ctrl + Shift + F*

Finalize — *Click Create Service Area IDs button (or Ctrl + Shift + S) to create service area ids based on your state*

Service Area IDs will populate in the drop-down box in Service Area ID column

For each row, enter one County for that Service Area ID (unless the Service Area covers entire state)

HIOS Issuer ID:*

Issuer State:* NV

Create Service Area IDs

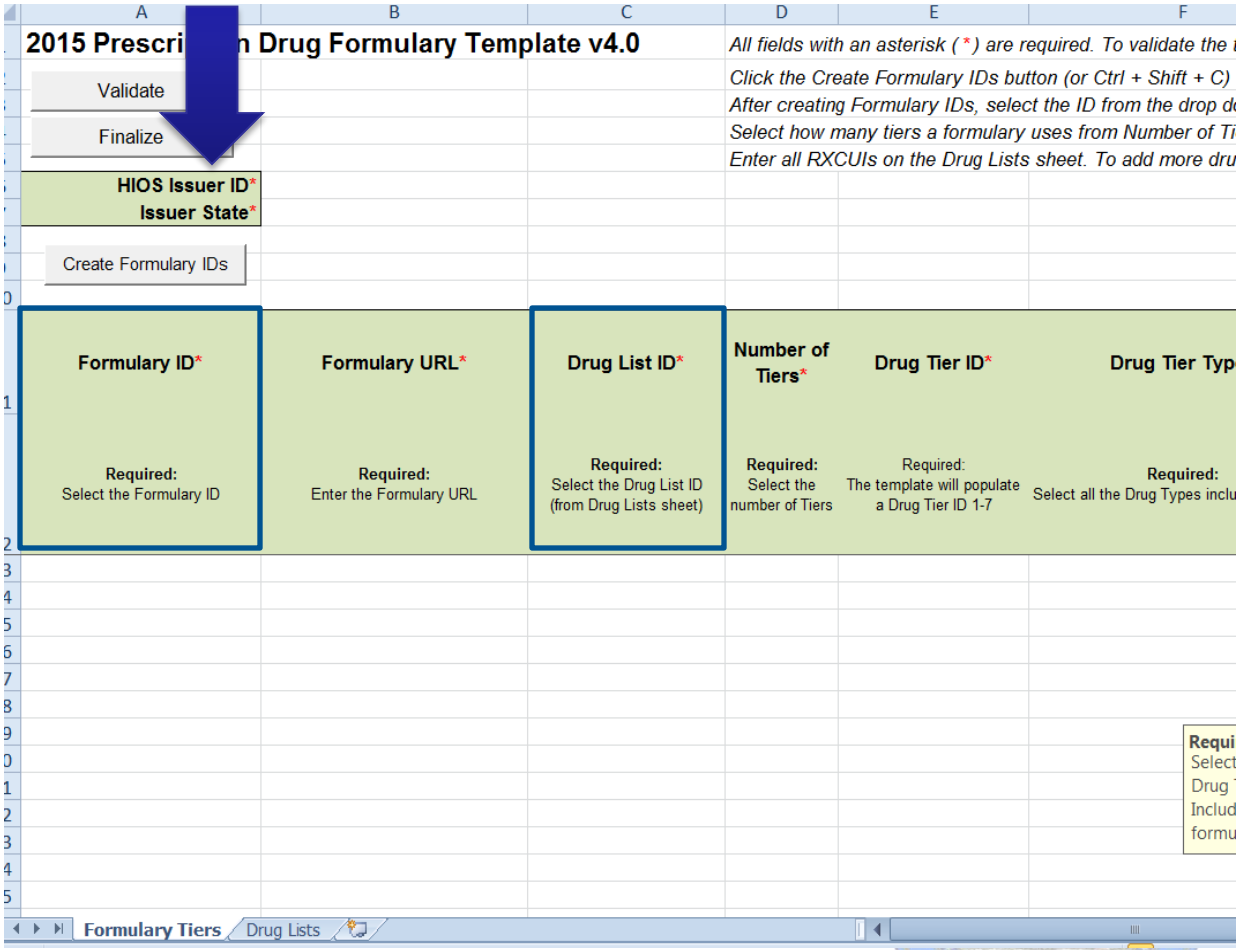
Service Area ID* Required: Enter the Service Area ID	Service Area Name* Required: Enter the Service Area Name	State* Required: Does this Service Area cover the entire state?	County Name Required if State is "No": Select the County - FIPS this Service Area covers	Partial County Required if State is "No": Does this Service Area include a partial county?	Service Area Zip Code(s) Required if Partial County is "Yes": Enter the zip codes in this county that are covered by this Service Area	Partial County Justification Required if Partial County is "Yes": Enter a Justification of why all of the zip codes are not included in this service area.
NVS001	Service Area 1	No	Washoe - 32031	Yes	89505, 89506, 89507	
NVS002	Service Area 2	No	Clark - 32003	No		
NVS002	Service Area 2	No	Nye - 32023	No		
NVS003	Service Area 3	No	Clark - 32003	No		
NVS003	Service Area 3	No	Nye - 32023	No		
NVS003	Service Area 3	No	Lincoln - 32017	No		
NVS003	Service Area 3	No	Esmeralda - 32009	No		
NVS004	Service Area 4	Yes				

Prescription Drug Template – Formulary Tiers tab

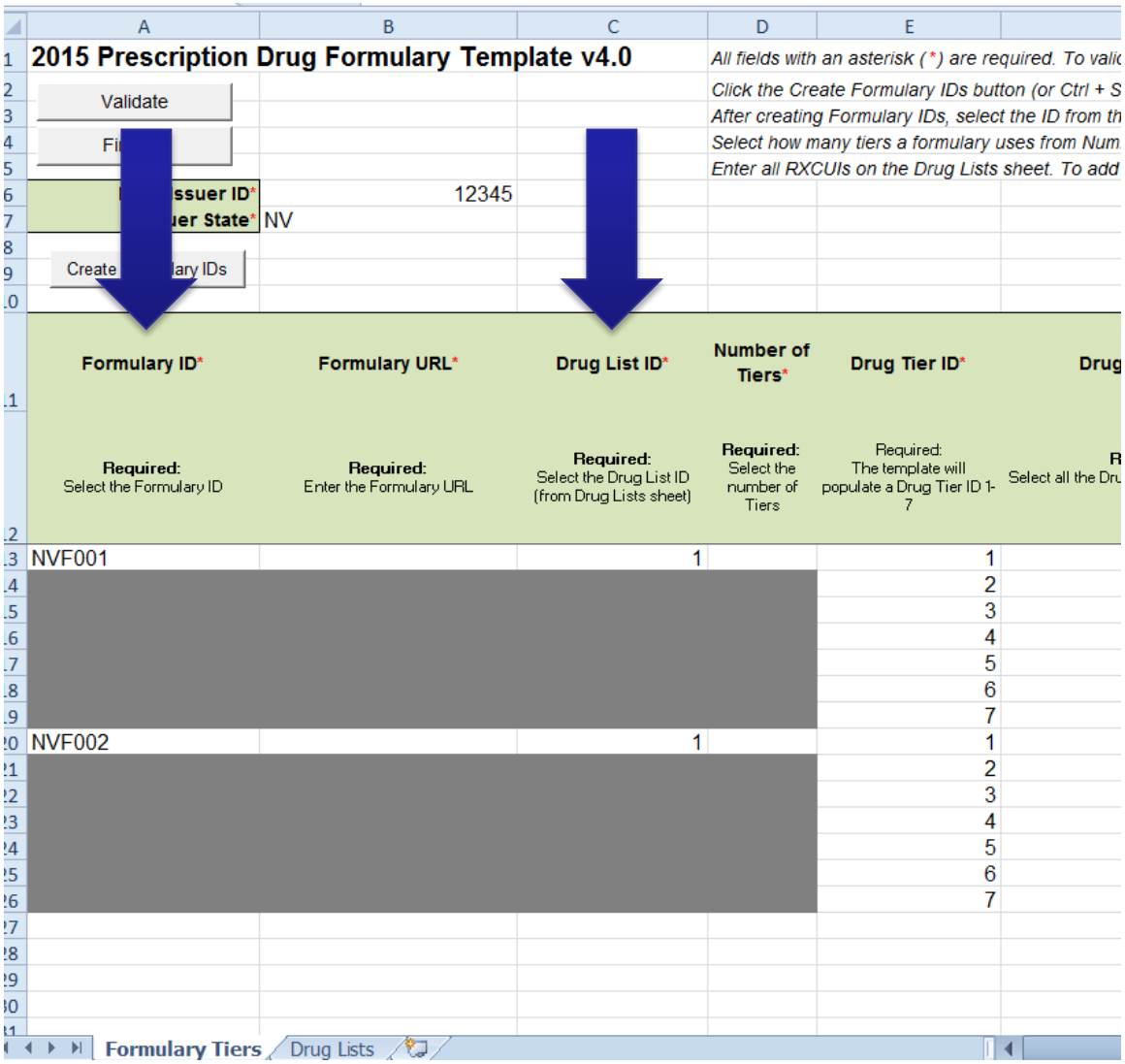
Only the Formulary ID and Drug List ID are required fields on the Formulary Tiers tab for off-exchange submissions.

1. Select Issuer State, enter HIOS ID, & create Formulary IDs
2. Proceed to link each ID to a drug list
3. Drug Tier ID will auto-populate & some fields will blackout – please ignore

✓ The Drug Lists tab should be completed first



Formulary Tiers Tab Example:



2015 Prescription Drug Formulary Template v4.0

All fields with an asterisk (*) are required. To valid
Click the Create Formulary IDs button (or Ctrl + S
After creating Formulary IDs, select the ID from th
Select how many tiers a formulary uses from Num
Enter all RXCUIs on the Drug Lists sheet. To add

Validate

Fi

ssuer ID* 12345

er State* NV

Create ary IDs

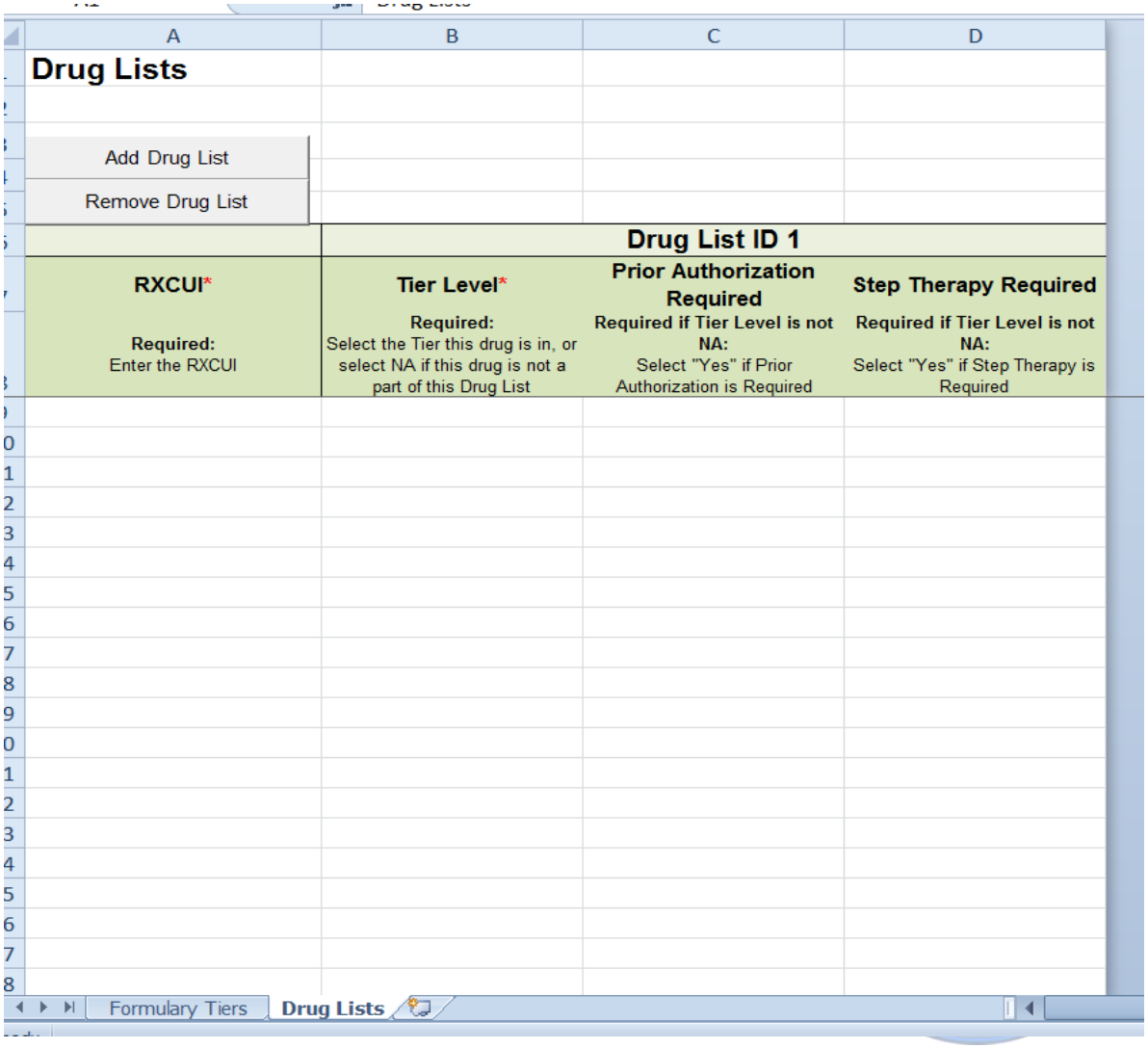
Formulary ID*	Formulary URL*	Drug List ID*	Number of Tiers*	Drug Tier ID*	Drug
Required: Select the Formulary ID	Required: Enter the Formulary URL	Required: Select the Drug List ID (from Drug Lists sheet)	Required: Select the number of Tiers	Required: The template will populate a Drug Tier ID 1-7	R Select all the Dru
NVF001		1		1	
				2	
				3	
				4	
				5	
				6	
				7	
NVF002		1		1	
				2	
				3	
				4	
				5	
				6	
				7	

Formulary Tiers | Drug Lists

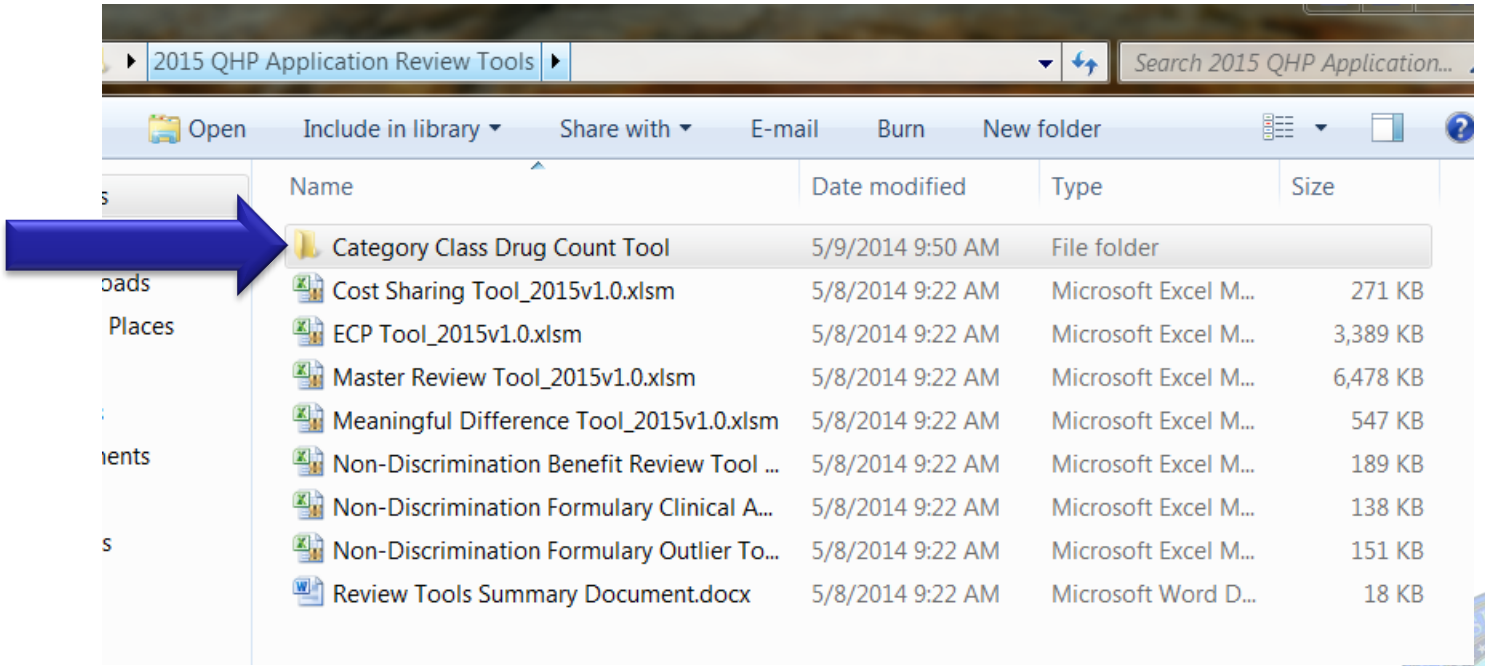
Prescription Drug Template – Drug Lists tab

All fields are required on the Drug Lists tab for off-exchange submissions.

- ✓ Formularies will be evaluated for discriminatory benefit design
- ✓ USP classes with an unusually large number of drugs subject to step therapy and/or prior authorization may require adjustments

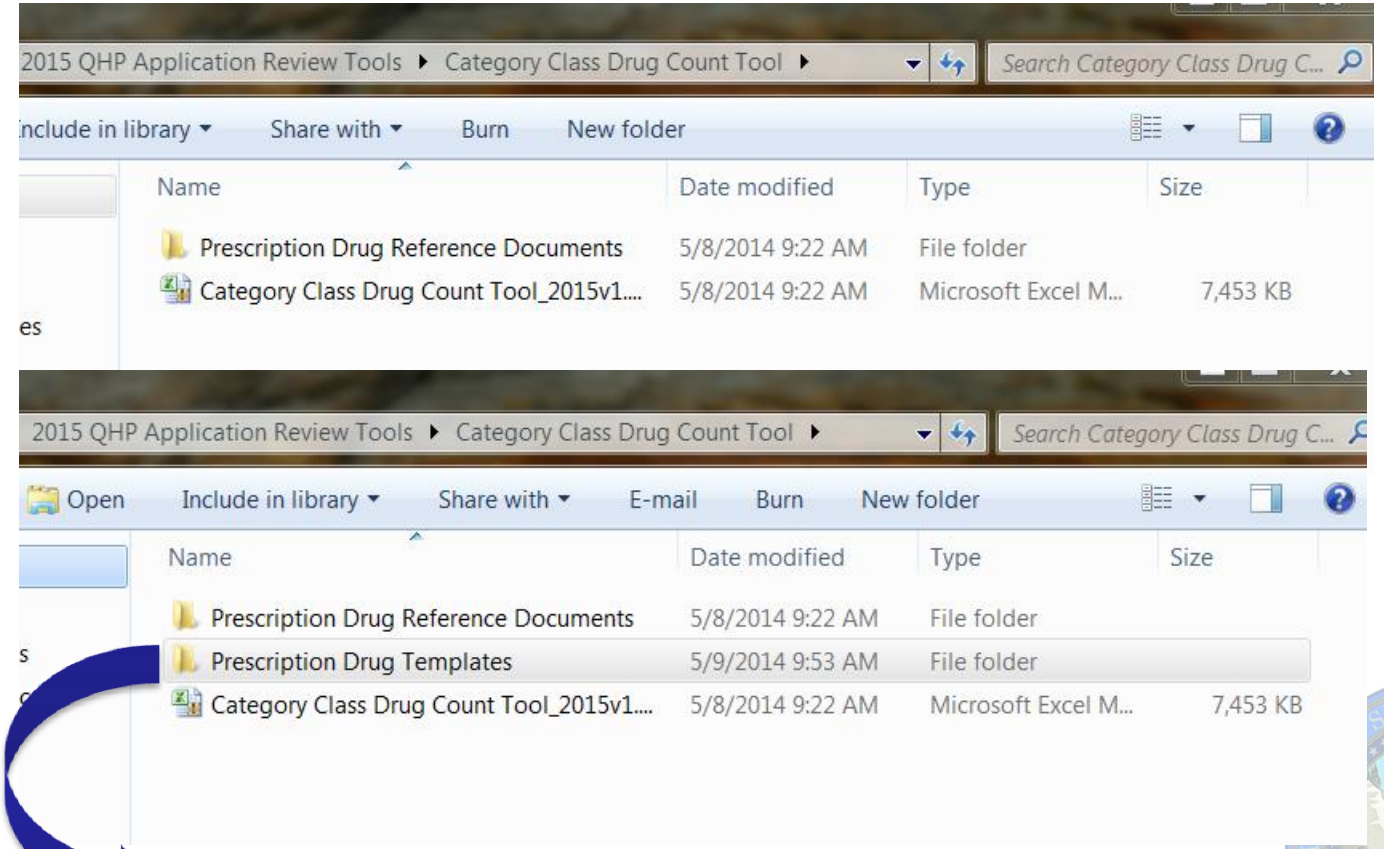


Category Class Count Tool



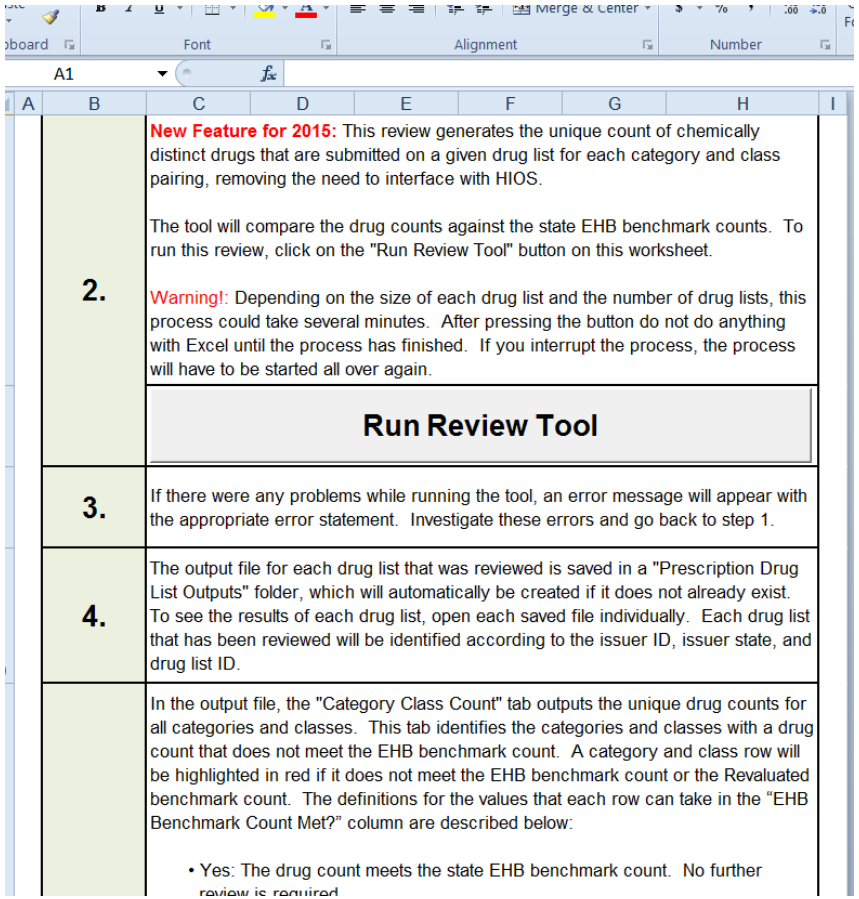
Division of Insurance

Step 1: Create a folder named “Prescription Drug Templates” inside the same folder as the tool



Save all completed Prescription Drug Templates here

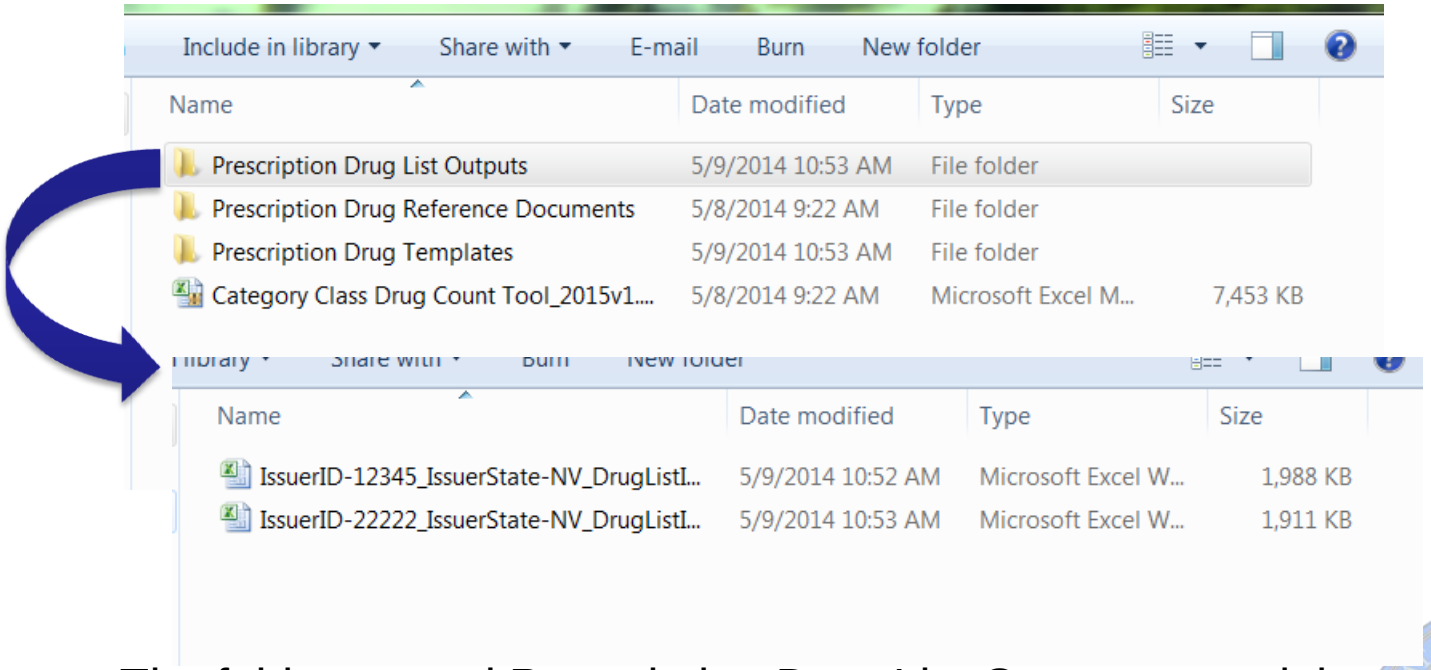
Step 2: Run the Review Tool



2.	**New Feature for 2015:** This review generates the unique count of chemically distinct drugs that are submitted on a given drug list for each category and class pairing, removing the need to interface with HIOS. The tool will compare the drug counts against the state EHB benchmark counts. To run this review, click on the "Run Review Tool" button on this worksheet. Warning!: Depending on the size of each drug list and the number of drug lists, this process could take several minutes. After pressing the button do not do anything with Excel until the process has finished. If you interrupt the process, the process will have to be started all over again. **Run Review Tool**
3.	If there were any problems while running the tool, an error message will appear with the appropriate error statement. Investigate these errors and go back to step 1.
4.	The output file for each drug list that was reviewed is saved in a "Prescription Drug List Outputs" folder, which will automatically be created if it does not already exist. To see the results of each drug list, open each saved file individually. Each drug list that has been reviewed will be identified according to the issuer ID, issuer state, and drug list ID.
	In the output file, the "Category Class Count" tab outputs the unique drug counts for all categories and classes. This tab identifies the categories and classes with a drug count that does not meet the EHB benchmark count. A category and class row will be highlighted in red if it does not meet the EHB benchmark count or the Revaluated benchmark count. The definitions for the values that each row can take in the "EHB Benchmark Count Met?" column are described below: • Yes: The drug count meets the state EHB benchmark count. No further review is required

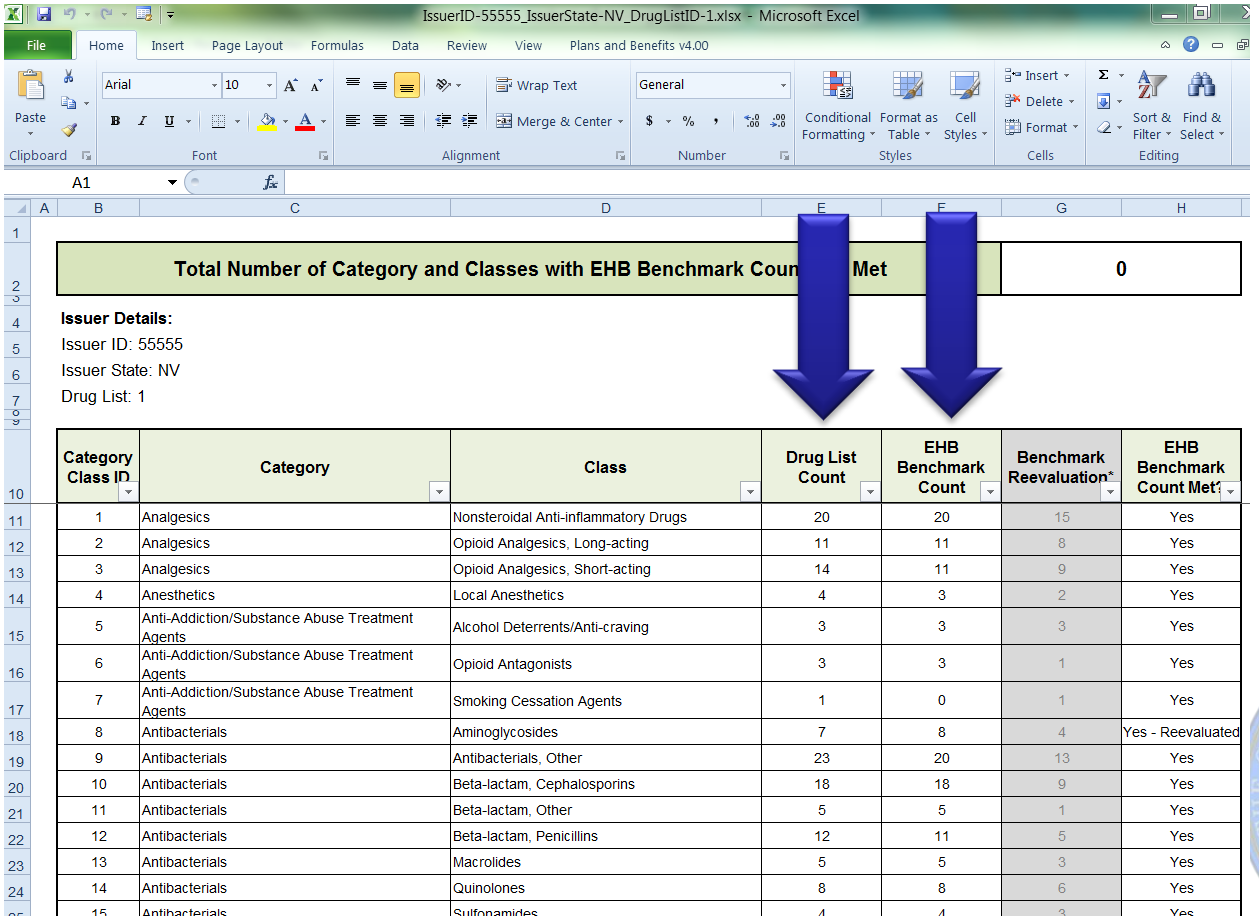
All templates saved inside the Prescription Drug Templates folder will simultaneously be evaluated

Step 3: Drug count outputs can now be accessed



The folder named Prescription Drug List Outputs containing a separate evaluation of all drug lists will be automatically generated

Step 4: Compare Drug List Count to EHB Benchmark Count to identify any drug shortages

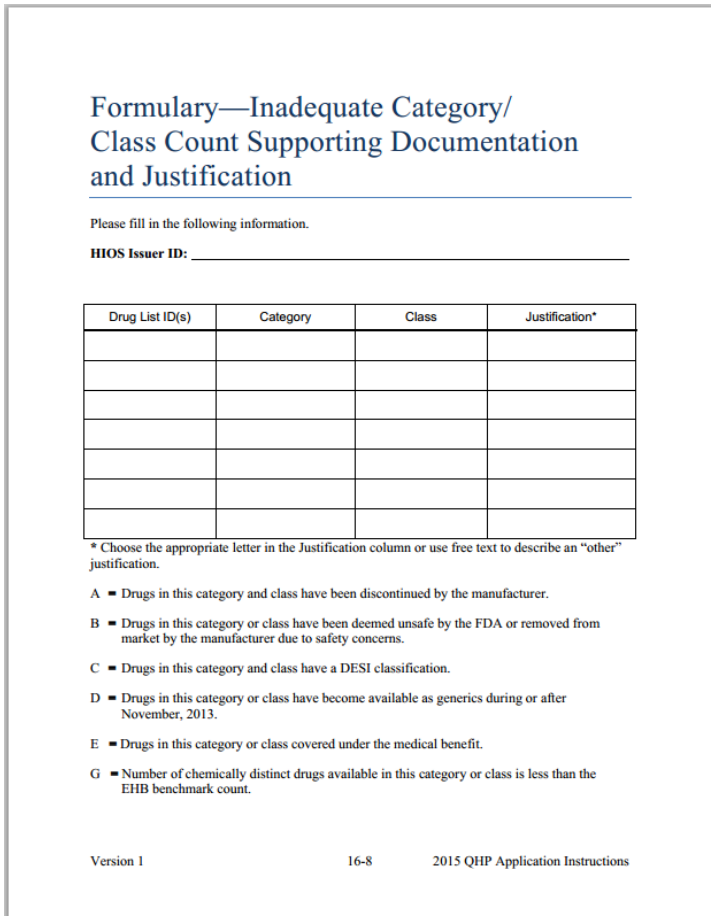


Total Number of Category and Classes with EHB Benchmark Coun Met | **0**

Issuer Details:
Issuer ID: 55555
Issuer State: NV
Drug List: 1

Category Class ID	Category	Class	Drug List Count	EHB Benchmark Count	Benchmark Reevaluation*	EHB Benchmark Count Met?
1	Analgesics	Nonsteroidal Anti-inflammatory Drugs	20	20	15	Yes
2	Analgesics	Opioid Analgesics, Long-acting	11	11	8	Yes
3	Analgesics	Opioid Analgesics, Short-acting	14	11	9	Yes
4	Anesthetics	Local Anesthetics	4	3	2	Yes
5	Anti-Addiction/Substance Abuse Treatment Agents	Alcohol Deterrents/Anti-craving	3	3	3	Yes
6	Anti-Addiction/Substance Abuse Treatment Agents	Opioid Antagonists	3	3	1	Yes
7	Anti-Addiction/Substance Abuse Treatment Agents	Smoking Cessation Agents	1	0	1	Yes
8	Antibacterials	Aminoglycosides	7	8	4	Yes - Reevaluated
9	Antibacterials	Antibacterials, Other	23	20	13	Yes
10	Antibacterials	Beta-lactam, Cephalosporins	18	18	9	Yes
11	Antibacterials	Beta-lactam, Other	5	5	1	Yes
12	Antibacterials	Beta-lactam, Penicillins	12	11	5	Yes
13	Antibacterials	Macrolides	5	5	3	Yes
14	Antibacterials	Quinolones	8	8	6	Yes
15	Antibacterials	Sulfonamides	4	4	3	Yes

Inadequate Category/Class Count Supporting Documentation



Formulary—Inadequate Category/
Class Count Supporting Documentation
and Justification

Please fill in the following information.

HIOS Issuer ID: _____

Drug List ID(s)	Category	Class	Justification*

* Choose the appropriate letter in the Justification column or use free text to describe an "other" justification.

A = Drugs in this category and class have been discontinued by the manufacturer.

B = Drugs in this category or class have been deemed unsafe by the FDA or removed from market by the manufacturer due to safety concerns.

C = Drugs in this category and class have a DESI classification.

D = Drugs in this category or class have become available as generics during or after November, 2013.

E = Drugs in this category or class covered under the medical benefit.

G = Number of chemically distinct drugs available in this category or class is less than the EHB benchmark count.

Version 1 16-8 2015 QHP Application Instructions

This can be found here:

http://www.serff.com/documents/plan_management_data_instructions_ch16c_2015.pdf

Schedule of Benefits: Embedded Pediatric Dental

- Explanations of Type I, Type II, Type III, and Type IV dental services must be included.
  - Every service does not need to be listed in the Schedule of Benefits; however, important services of each category should be listed.
  - A detailed list of pediatric dental services should be included in the **Certificate of Coverage**.

Schedule of Benefits: Embedded Pediatric Dental

Covered Services and Limitations	Plan Provider	Non-Plan Provider *Member pays amount listed plus any amounts exceeding the Allowable Expenses and benefit maximums.*
Pediatric Dental • Class I P&D • Class II – Basic • Class III – Major • Class IV – Orthodontia* **Covered when Medically Necessary* *A $100 Deductible applies to Class II to Class IV Services.*	After CYD, Member pays: 0% of Allowable Expenses. 25% of Allowable Expenses. 50% of Allowable Expenses. 50% of Allowable Expenses.	After CYD, Member pays 50% of Allowable Expenses.

Schedule of Benefits: Embedded Pediatric Dental

Pediatric Dental - Pediatric Dental Coverage up to Age 19	
• Calendar Year Deductible	$50 Single, 3X Family
• Diagnostic and Preventive Services	No Charge
• Basic Restorative Procedures - Deductible applies.	20% Coinsurance
• Major Restorative Procedures - Deductible applies.	50% Coinsurance
• Orthodontia[3] - Deductible applies.	50% Coinsurance

Schedule of Benefits: Embedded Pediatric Dental

- For pediatric dental, Type I dental services (preventive and diagnostic services) cannot be subject to the deductible.

Schedule of Benefits: Embedded Pediatric Dental

Pediatric Dental	In-Network	Out-Of-Network
Individual Pediatric Deductible *(applied to all services)*	$60	$120
Family Pediatric Deductible *(applied to all services)*	$120	$240
Individual Pediatric Maximum Out-of-Pocket *(applied to all services)*	$1,000	$2,000
Family Pediatric Maximum Out-of-Pocket *(applied to all services)*	$2,000	$4,000

Mental Health Parity

- Financial requirements and treatment limitations for mental health and substance abuse cannot be more restrictive than the requirements applied to medical benefits
- A financial requirement or treatment limitation is considered to apply to all medical benefits if it applies to two-thirds or more of the medical benefits for the same classification
- Safe Harbor benefit designs are in parity with PCP financial requirements
- Carriers must provide supporting documentation for benefit designs in parity with specialist financial requirements
  - Demonstrate that the predominant type of financial requirement within a classification is associated with specialty providers
- Plans must also be in parity with respect to nonquantitative treatment limitations such as medical management standards

Schedule of Benefits

Mental Health –* ***-Subject to CYD***	Member Responsibility (In-Network)
Inpatient medically necessary services for mental health disorders	$500*
Outpatient and office visits – Mental health *(Authorization required for more than 12 visits per Calendar Year)*	$30*

Physician Office Visits – **** -Subject to CYD***	Member Responsibility (In-Network)
Primary care (PCP)	$30*
Primary care - wellness visit PPACA covered	$0
Obstetrics and gynecology for PPACA services	$0
Specialist care	$50*

No referral is required for these visits. All necessary wellness visits are covered for children less than two years of age. One wellness visit per year is covered for members older than two or as frequently as mandated by ACA.